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### Original Citation

Munro, Ian and Edward, Karen-Leigh (2009) Best Practice in Relation to Seeking and Maintaining Employment for People with Depression and Other Mental Illnesses. *Mental Health and Learning Disabilities Research and Practice*, 6 (2). pp. 229-245. ISSN 1743-6885

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**Best Practice in Relation to Seeking and Maintaining Employment for  
People with Depression and Other Mental Illnesses**

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## Best Practice in Relation to Seeking and Maintaining Employment for People with Depression and Other Mental Illnesses

Ian Munro & Karen-Leigh Edward

### Abstract

**Objective:** The pilot study aimed to evaluate the Disability Open Employment Services (DOES), now called the Disability Employment Network (DEN), developed by the Australian Federal Government to assist clients with health disabilities to seek and maintain employment. This is the first time this type of programme has been evaluated in a service delivery setting in Australia.

**Method:** This study employed a mixed method design for inquiry.

**Findings:** Male participants reported less symptom interference with work duties than females. There was also an association of gender on mental health with males reporting lower levels of mental health than females. There was an association of employment goal on the degree to which symptoms interfered with work duties where those whose goal was full time work experienced significantly more interference from their symptoms than other individuals. Key findings relate to the fragmentation of current services and the variability in the educational preparation of employment counsellors.

**Implications and Conclusions:** Implications for practice relate to the enhancement of the provision of employment services to people with a mental illness. Further research is required into the factors which clients perceive as enabling or inhibiting their participation in employment support services and further knowledge is also required about how employment support services and mental health organisations can work together as interlocked services.

**Key words:** Australia, depression, mental illness, vocational support, employment services, mental health nursing

### Introduction

This pilot study was an in-depth exploration of employment factors and their impact on clients with depressive disorders and other mental illnesses who receive vocational support services. The findings present issues and practices described by staff and clients of Disability Open Employment Services (DOES), now called Disability Employment Network (DEN). The DEN was developed by the Australian Federal Government to assist clients with health disabilities to seek and maintain employment. DEN service provider organisations are contracted by the Department of Employment and Workplace Relations (DEWR). This service approach generally provides one or more of the following services and outcomes for individuals: training support; assistance in finding a job and starting employment; and continuing support once the individual has gained employment. There are currently informal links between DEN and mental health services. In 2005 the Australian Government's Welfare to Work reforms introduced new budget measures to address the needs of people with a disability, including those with mental illness. The DEN programme helps put into action these measures and aims to increase workforce participation among working age Australians by focusing on a person's capacity for work (DEWR 2006). There are approximately 69 DEN programmes in the State of Victoria (where this study was conducted), and 236 programmes Australia wide. This is the first time this type of programme has been evaluated in a service delivery setting in Australia.

## **Background**

Those who experience mental illness (MI) find reconnecting into employment difficult and complex. Depression and other MIs are linked with considerable costs to the person, their carers and the community. Some costs are self-evident, such as an individual loss in self esteem and a decline in general well-being, physical impairments due to the side-effects of medication, increased monetary costs towards treatment and care, and the productivity losses or impaired work performance resulting from their disability. Importantly, there remains a high non-participation in the labour force and unacceptable levels of unemployment for people with MI, with estimates of between 60-90% found in the United States of America, the United Kingdom, and Australia (Hughes 1999; Waghorn, Chant, White & Whiteford 2004). The Australian Bureau of Statistics (2007) found in 2003, that most working-age people with a disability (58%) who were not in the labour force reported being permanently unable to work. The majority (52%) of those permanently unable to work were aged 55 years or older. Interestingly, some disability groups had higher rates of reported permanent incapacity for work than others. For example, 48% of people with a psychological disability reported being permanently unable to work, compared with 28% of those with a sensory disability (Australian Bureau of Statistics (ABS) 2007).

The academic literature suggests employers have concerns about individuals with depression and other mental illnesses as they regard those workers to have poor work performance and poor quality of work (Diksa & Rogers 1996; Hand & Tryssenaar 2006; Johnson, Greenwood & Schriener 1988). Stigma and discriminatory action in employment may be understood in terms of public stigma, which is representative of the general public's attitudes towards people with psychiatric disorders. This may include such reactions as pity, anger, a belief of dangerousness, and fear (Corrigan, Larson & Kuwabara 2007). Additionally, workplace stigma may occur as a consequence of the obvious physical signs of psychotropic medication, such as tardive dyskinesia, akathisia, over secretion of saliva and tremor associated with taking medication for psychosis (Baldwin & Marcus 2006). Individuals who take antidepressant medication can have side effects which include dry mouth, blurred vision, sedation (can interfere with driving or operating machinery), weight gain, agitation and anxiety. Furthermore, one's personal reaction to the stigma of MI (self-stigma) can also lead to significant losses to self esteem, feelings of anger and frustration, social exclusion, embarrassment and potential barriers to recovery, rehabilitation and re-employment (Corrigan, Watson & Barr 2006).

Current research points to the need for new interventions that can provide individualised support which integrates both personal and occupational support for individuals experiencing depression and other MIs; such as: faster return to work; using work as part of the recovery process; and careful matching of individuals to appropriate jobs based on preferences and work capabilities (Drake et al 1999; King et al 2006; Perkins 2006; Secker & Gelling 2006). Reconnection with employment facilitates self-determination and self-efficacy for those who experience MI. The text *Making Recovery a Reality* (Shepherd et al 2008) identifies the problems of stigma and discrimination have to be addressed, and remain major barriers to people with mental health problems being able to gain employment and develop meaningful lives. The evidence base created by this evaluation is intended to inform the employment support service model for individuals living with MI. The study aims include:

- To evaluate client and staff perceptions and experiences of the DEN programme in assisting people with depression and other related mental illnesses to seek and maintain employment;

- Build an evidence base that would assist other services working with people with mental health issues to improve service provision around depression and other mental health problems;
- Add to existing knowledge on the subject of Disability Employment Support for people who experience depression and other mental illnesses;
- Provide recommendations to inform the service model and future research in the area of Disability Employment Support for people who experience depression and other mental illnesses.

## **Method**

### **Design**

This study employed a mixed method quantitative-qualitative approach with two participant groups, in the hope to gain meaningful data from the two research paradigms. The researchers used two validated instruments: SF-12, WRSE-38 and a socio-demographic survey to explicate quantitative data. In-depth semi-structured interviews and focus groups were used to achieve a greater understanding of participants' meaning and lived experience of their employment circumstances, goals and outcomes. The choice of in-depth and focus group interviews allowed researchers to gain information from participants who have a common bond, which Dempsey and Dempsey (2000) argue can assist in the evaluation of service delivery.

### **The Instruments**

The SF-12's parent measure (the SF-36) is shown to be a reliable and valid tool and has been used effectively in mental health settings with mental health clients. Research has demonstrated scores calculated from the SF-36 (PCS and MCS) or a sub-set of 12 items (the SF-12) were virtually identical, and indicated the same magnitude of ill-health and degree of change over time (Jenkinson et al 1997). It is for this purpose the SF-12 was selected for use in this study.

The SF (Short Form) -12 comprises: two questions about physical functioning; two questions on role limitations because of physical health problems; one question about bodily pain; one question related to general health perceptions; one question on vitality, energy/fatigue; one question on social functioning; two questions about role limitations because of emotional problems; and two questions on general mental health. The 12 items on the SF-12 are summarised in two weighted summary scales - mental health score (MCS) and physical health score (PCS) - where lower scores indicate more severe disability. Scoring of individual items is identical to the SF-36 Health Survey. Scoring algorithms are then applied to produce the PCS and MCS scores.

The physical and mental component summary scales (PCS and MCS) were measured using a norm-based method. Original regression weight for the PCS and the MCS are derived from the United States of America population (Ware, Kosinski & Keller 1998). The use of the SF-12 is appropriate to the Australian community where population health data using the SF-12 can be found in the 1997 Australian National Survey of Mental Health and Well-Being (ABS 1998) and the 2000 Mental Health Status of South Australian Population Study (Taylor et al 2000). The advantages of standardization and norm based scoring are that the results for one can be meaningfully compared to the other. In norm-based scoring, each scale is scored to have the same average (50) and the same standard deviation (10 points). Both the PCS-12 and MCS-12 scales have a mean value of 50 ( $SD=10$ ). All scores

above and below 50 ( $SD = 10$ ) are considered above or below the average (Ware, Kosinski & Keller 1998). The SF-12 takes approximately 10 minutes to complete.

The WRSE (Work-Related Subjective Experience) 38 item instrument assesses work-related subjective experiences. For this study we sought the subjective insights about the intersection of the person, the disorder and expectations and employment functioning. This instrument provided the researchers with the opportunity to explore and discuss with clients their individual assistance needs and perceived working capacity.

Participants circle the number of any of the 38 statements which they have experienced in the past six months. Then, for only those experiences, circle the number which best describes how confident they could manage employment when this experience or behaviour is present. Confidence rating was measured from 0% - 100%. A score of 0% means they had no confidence in their ability to work in the job of their choice to the standard required by an employer if the experience or behaviour described was present. A score of 100% means they were totally confident in their work ability. The WRSE-38 scale has face validity grounded in consumer reports, construct validity, high internal consistency, elements of test-retest stability and reliability, criterion validity and conceptual links to career development and to self-efficacy, an established predictor of work performance (Drake, Chant & King 2005: 295). The questionnaire takes approximately 20-30 minutes to complete.

## **Participating Sites and Sample**

A convenience sample of two DEN programmes was recruited to participate in this research. One was located in metropolitan Melbourne, the other in a regional location, this allowed the researchers to compare and contrast the experiences. The sample consisted of employment counsellors and DEN clients who experience a depression or other MI.

## **Recruitment**

Recruitment of both staff and client participants was undertaken by advertising and information presentations conducted by the research team. Interested individuals were provided with a plain language statement (PLS) about the study. Following the provision of written consent to participate, they were given the survey/questionnaires by the project officer. Participants who indicated on their consent form their intention to participate in a semi-structured interview or a focus group, and had provided a contact number, were telephoned by the project officer to arrange a time convenient for the participant.

## **Inclusion and Exclusion Criteria**

Potential participants were screened on the basis of several inclusion and exclusion criteria.

### **Inclusion Criteria for Clients**

- A current client of the employment support service DEN programme.
- Between the ages of 18-64 years.
- Self report of experiencing depression and related disorders.

### **Inclusion Criteria for Staff**

A current DEN staff member of the employment support service.

## **Exclusion Criteria for All Participants**

Participants who are under 18 years of age, unable to comprehend and read English or those demonstrating pronounced psychological distress were not recruited. Participants were also excluded if they had cognitive impairment that would influence their ability to understand the consent process.

## **Ethics**

Ethics approval was provided by the University Human Research Ethics Committee. Ethical considerations included confidentiality, anonymity and risks and benefits.

## **Confidentiality and Anonymity**

Participants were allocated a number by the researcher in an effort to enhance anonymity. Burns and Grove (2001) rightly point out that anonymity could not be guaranteed in focus groups; however, participants were reminded of the confidential nature of the focus group discussions. Employment agencies are referred to generically and individual workers within those agencies were not identified in any manner.

## **Risks and Benefits**

The potential risks identified in this study related to clients discussing their problems within a group setting. In doing so, they could be 'exposed' to the concerns and problems of other clients. Such knowledge could heighten their level of anxiety. Despite this concern, Burns and Grove (2001) claim focus groups offer participants 'safety in numbers' allowing participants to speak freely with researchers. To address the possibility of increased anxiety, a highly skilled mental health clinician with knowledge of the experiences of clients with a MI and the research process conducted the group interviews. The same level of expertise was held by the researcher who collected information from the staff. If participants became stressed, or suffered any discomfort from the research process, they were offered counselling free of charge. This did not occur during the study. There were no known benefits for participants in this study.

## **Data Collection**

Data were collected using a mixed method design. Quantitative research methods were used to determine process and client factors involved in successful work outcomes. All clients with a self reported diagnosis of a depressive disorder and other related mental illnesses were invited to complete a socio-demographic form and validated psychometric instruments, the SF-12 and the WRSE-38 (Waghorn, Chant & King 2005). Sample size calculations indicated a sample of approximately 80 clients was required. Due to recruitment limitations, implicated in the selection criteria, 35 clients participated. There were 7 staff and 35 clients; 42 total participants. This study's sample was not meant to quantify general performance within a population but merely to document the barriers and benefits of the DEN programme from both the staff and client perspectives. In this context, meaningful findings were elucidated from analyses.

Of the participants, 16 clients and 7 staff self-selected for a one-to-one semi-structured interview or participation in a focus group session. The focus groups were guided by the focus question 'Can you please describe your experience of the Disability Employment Network?' Seven clients participated in focus groups and the remaining nine participated in a one-to-one interview with the project officer. The research participants were more than

willing to discuss their concerns or praise the DEN, thus supporting Burns and Groves (2001) assertion about feeling safe in groups.

There was one staff focus group held for 3 staff, with the remaining 4 staff involved in a one-to-one interview with the project officer. The mode of participation depended on the time and availability of the participants and on the service needs of the employment agency. A narrative interview approach modelled on the biographic-narrative-interpretive-methods approach (Bandura 1977) was employed, allowing the client to tell *their story* of their experience in seeking or maintaining work. Narrative data was collected until data saturation occurred at 16 clients and 7 staff. The questions used to prompt and guide the interviews are presented in Table 1.



**Table 1: Guiding Questions Used for Qualitative Interviews and Focus Groups**

Client Questions	Employment Counsellor Questions
<ol style="list-style-type: none"> <li>1. What is/are the reasons that you are attending this employment service?</li> <li>2. Did you find accessing the employment service difficult/relatively easy?</li> <li>3. How long have you been coming to this employment service?</li> <li>4. Are you currently working?</li> <li>5. How long has it been since you were last working?</li> <li>6. When you last worked, how long did the job last?</li> <li>7. Are you confident that you will soon be working?</li> <li>8. What do you think will help you to secure employment?</li> <li>9. Do you have confidence that your case manager can assist you to find work?</li> <li>10. Will anything hinder your chances of gaining employment?</li> <li>11. Tell me what skill areas you have worked on at the employment service?</li> <li>12. Do you spend a lot of time thinking about working?</li> <li>13. How do you feel when you get a job interview?</li> <li>14. Has your condition impacted on your work experience? If so, in what way/s?</li> <li>15. Have you had to adjust your view of your job searching because of your health condition?</li> <li>16. Has the employment service helped you in this adjustment? If so, in what way/s?</li> <li>17. Do you see your potential/future employment success coming from the employment service?</li> <li>18. Can you see yourself being successful at a job interview?</li> <li>19. Do you believe that support of an employment service will assist you to continue working?</li> </ol>	<ol style="list-style-type: none"> <li>1. How long have you been working in the disability open employment programme?</li> <li>2. How do clients access the programme?</li> <li>3. What do you see as some of the problems that clients of your service face when applying for employment?</li> <li>4. What strategies have you found work well for the clients who you see?</li> <li>5. What areas do you have concerns about when you refer clients for a job?</li> <li>6. Are there any programmes or strategies that you think would work well for this client group?</li> </ol>

## **Data Analyses**

Quantitative analysis was undertaken using SPSS (version 14 for Windows) for data collected via the socio-demographic survey and the SF12 and WRSE-38 instruments. Qualitative data was audio-taped and transcribed verbatim for content analysis. The qualitative software programme NVivo (version 7) was used for qualitative analysis.

Data from the surveys were analysed to produce demographic profiles of the staff and client cohorts. Analyses of the client data also generated findings related to the effects of specific variables on four dependent variables: (1) participants' reported physical health, (2) participants' reported mental health, (3) number of symptoms experienced, and (4) the extent to which these symptoms interfered with employment.

## **The Staff**

Most of the seven staff – four metropolitan and three regional - were in the 40-45 age bracket and had been employed in the field from 3-10+ years. The cohort consisted of one male and six females. Four of the seven held tertiary qualifications; the others were studying. All indicated they had received professional development support, such as supervision and in-house education, and/or were supported in achieving external education related to the field. No statistical analyses were undertaken with the staff data.

The most significant recurrent staff statements related to fragmentation across services (28 significant statements) and identification of specific difficulties staff perceived as barriers for their clients (22 significant statements). This pattern represented 53% of the total staff statements. The 33 theme clusters were coded into two overarching concepts articulated by staff and clients participants: Barriers to employment and Enablers to employment.

## **Barriers to Employment**

The staff identified six barriers to clients' ability to obtain and retain employment. Four related to organisation practices while two related directly to clients' health status:

- Inappropriate referrals;
- Impact of MI on clients' working capacity and work readiness for employment;
- Stigma and discrimination as a result of disclosure to employer;
- Finding a job appropriate to match clients' limitations and abilities;
- Fragmentation of services, reducing continuity for clients;
- Government policy changes to the DEN programmes.

## **Enablers to Employment**

Staff identified the enablers to employment for their clients which included: using an individualised approach (ie: working with clients in relation to their recovery phase); receiving appropriate referrals from other agencies; sharing information between other services; accurate assessment of clients' readiness for work; being accountable and pro-active in regard to clients' needs; assertive follow-up; and establishing clients' pre-existing work experience and skills set.

## **The Clients**

The client cohort consisted of 14 women and 21 men; 18 were from metropolitan and 17 from regional areas. The mean age of clients was 43 years (*SD* 14.1 years). Of the client

cohort, nine were employed on a casual, part-time or full-time basis in competitive employment. One client was engaged in volunteer work. The remaining 25 clients were unemployed; the period of unemployment ranged from two months to 20 years. The reasons cited for leaving their last job included limited support, physical injury, unlawfully dismissed, unfair treatment, lack of hours, inconsistent shifts, drug addiction, illness, relapse of MI, not coping at work and stress. Most clients indicated their employment goal was to be in part-time or full-time employment.

Given the small size of the sample, data were screened ungrouped. Four one-way ANOVAs were conducted to examine the effect of diagnosis on the dependent variables. The variable had four levels: 1 = Affective disorder; 2 = Anxiety disorder; 3 = Dual diagnosis of affective and anxiety disorders; and 4 = Psychosis. Data analysis that did not reveal an effect will not be presented. Analyses revealed an association of the independent variable diagnosis on mental health ( $F(4,30) = 3.03, p < 0.05$ ). Post-hoc comparisons of the means from each condition revealed the difference was due to a diagnosis of depression and anxiety (dual diagnosis of affective and anxiety disorders) participants ( $M=27, SD=6.0$ ) reporting significantly lower levels of mental health than participants with psychosis ( $M=45, SD=9.5$ ).

There was a variance revealed of the independent variable gender on the degree to which symptoms interfered with work duties ( $F(1,33) = 5.79, p < 0.05$ ). Males ( $M=45, SD=20$ ) tended to report less interference than females ( $M=62, SD=23$ ). There was also a variance of the independent variable gender on mental health ( $F(1,33) = 9.73, p < 0.05$ ). Males ( $M=33, SD=12$ ) tended to report lower levels of mental health than females ( $M=46, SD=11$ ).

The independent variable employment goal on the degree to which symptoms interfered with work duties ( $F(3,31) = 5.22, p < 0.05$ ) demonstrated a variance. Post-hoc tests suggested for those whose goal was full time work experienced significantly more interference from their symptoms than all other individuals (i.e., those who had no goal, those who wanted to work part time or casually or volunteer work). This was despite there being no significant difference in the number of symptoms experienced (as evidenced by the non significant result of the employment goal on symptom number ANOVA). Correlations using Pearson's  $r$  between the four dependent variables were investigated and no significant relationships between them were found (Table 2). Pearson's correlation reflects the degree of linear relationship between two variables. It ranges from +1 to -1.

**Table 2 Pearson  $r$  Correlations between Age and Dependent Variables**

	Physical component score (PCS)	Mental component score (MCS)	Number of symptoms	Symptom mean
PCS	1			
MCS	-0.06	1		
Number of symptoms	0.03	-0.22	1	
Symptom mean	0.25	0.30	-0.22	1
Age	0.02	-0.03	-0.06	0.16

The narrative data from the client participants produced themes originating from 375 statements from clients. The most frequent client statements related to how the DEN programme helped them in their recovery (95 statements) and the negative impact of MI on their work readiness and work capacity (67 statements). This pattern represented 43% of all client significant statements.

The client cohort identified several attitudes and practices (not listed in order of importance) within the workplace and among employment programme staff which they had experienced and perceived as inhibiting their ability to obtain and retain employment:

- Lack of continuity of support person;
- Financial difficulties;
- Inadequate time in the programme;
- Limited skill-base and employment experience;
- Government changes to the referral and assessment process;
- Impact of mental health status on working ability;
- Inflexible employment opportunities;
- Fear of discrimination if mental health status revealed;
- Lack of comprehension of needs by support service employee.

Eleven factors were identified by the clients as fostering their ability to obtain and retain employment within the workplace and employment programme. These included: making one's own choices; developing confidence and skills; having a good relationship with the employment counsellor; having job flexibility that relates to their stage of recovery; having support from friends and family; having realistic personal and occupational goals; an open and friendly culture of the DEN programme; living close to their place of employment; looking after themselves both physically and mentally; employment counsellors having knowledge of MI and mental health; and having access to training courses.

## **Discussion**

This study has achieved its aims which included exploring client and staff perceptions and experiences of the DEN programmes, to add to extant knowledge of the DEN programme for those who experience depression and other MI, and provide recommendations for future research in the area of employment support for those who experience depression and other mental illness.

A diagnosis of depression, or other MI, can prevent many individuals from participating effectively in the workforce and, for those who are in the workforce, may prevent the chance of career advancement. The topic of depression and other MI and employment is important since the global impact of psychiatric disability on the workforce is significant in terms of associated costs. In this study, the client cohort included people with diagnoses of affective disorder, anxiety disorder, dual diagnosis of affective and anxiety disorder, and psychosis. The combination of both depression and anxiety was identified in this study as producing significantly lower levels of reported mental health than other diagnoses. Epidemiological studies have revealed that the co-morbidity of anxiety and depression is very high (Kessler et al. 1998) but Tyrer, et al (2001: 56) argue 'only a proportion of clients with MI have simultaneous anxiety and depression'.

The study aimed to explore client and staff perceptions and experiences of the DEN programmes. These perceptions centred on employment as important to recovery. Interestingly, male clients in this study reported lower levels of mental health than females; however, they described less symptom interference with work. The findings reveal males experienced more symptoms of MI, however the symptoms did not impede their work capacity. Perhaps working was important to the improvement of mental well-being of the male participants or they were conforming to the male pattern of not disclosing illness. Indeed, academic literature reveals striking gender differences in mental health ability to identify, understand, interpret and communicate symptomatology (Cotton et al 2006; Kaneko & Motohashi 2007). In the main, males tend to show significantly lower recognition

of symptoms associated with MI and as such may contribute to the delays in help seeking behaviour seen in males (Cotton et al 2006).

The findings of this study also revealed that those with the goal of full-time work experienced significantly more interference from their symptoms than others (that is, those who had no work goal, who wanted to work part-time or casually or undertake volunteer work). This finding may be attributed to a number of factors, such as: the individual may have experienced more internal self-pressure to perform in order to reach their goal of full-time employment; they may have had to undertake more vocational training in preparation for full-time employment, leading to increases in stress levels or the individual's goal was unrealistic in the context of their work readiness and capacity. This finding suggests the stress adds to an increase in symptomatology. The influential work of Cannon (1914) and Selye (1956) suggest deviations from physiological and psychological stability result in a physiological and psychological response. In other words, under certain circumstances (i.e. increases in stress levels or a lack of personal resources) stressful situations may provoke emotional disturbances that can, in turn, result in the presence of, or increase in, psychosomatic or psychiatric symptoms.

Client and staff descriptions of employment barriers centred on the negative impact of MI on ability to work and the stigma of MI and potential discrimination in the workplace. Available literature purports the associated stigma of MI can result in significant reduction in self esteem, and has implications for employment in terms of performance from the individual and expectations from the employer (Corrigan & Watson 2002; Murphy & Murphy 2006). This can impact on quality of life, with good self-esteem being associated with a positive QoL and a sense of being more successful in vocational and social domains (Murphy & Murphy 2006).

A reduction in employment support service fragmentation for clients with mental disorders can enhance the achievement of re-employment, re-engagement with community and potentially recovery itself. To assist in this reduction or fragmentation of services provision, it is essential that mental health nurses assist clients in the recovery phase and work with clients in assisting them back into employment. This study's participants agreed that working at one's own pace, in the context of 'individual phase of recovery', was a distinct advantage in terms of enhancing motivation, confidence towards re-engagement and re-employment. Jacobson and Greenley (2001) describe a conceptual model of recovery from MI in which recovery refers to the experience of both internal and external conditions described by people who view themselves as 'being in recovery'. Such conditions include feeling hope, having a sense of empowerment and connection, experiencing a positive culture of healing and having access to recovery-oriented services, which support them in their recovery journey.

This study's findings support Drake et al (1999) in that individual placement and support in which employment specialists and mental health clinicians work together, can significantly assist clients to obtain competitive jobs and maintain employment. Drake et al's (1999) randomised clinical trial of supported employment attributed positive employment underpinning this style of employment support: supported employment integrated with treatment; a high level of client choice; competitive employment; and continuous follow-up support based on individual needs. The work of Pandiani and colleagues (2004), Drake and Bond (2008) and Evans & Bond (2008) also support this study's findings, where they suggest individuals who received mental health support and employment support simultaneously were significantly more likely to be employed than individuals who received vocational support services alone.

Recently, United States practice guidelines were put forward for employment support services for people with mental disorders, including the employment support service assisting the individual to find a job that supports recovery, training in money management, and the use of a team approach to integrate mental health and vocational services for clients. Additionally, peer support is increasingly recognised for its important role in addressing stigma and discrimination and facilitating improved mental health outcomes for mental health clients. Encouragingly, a new Australian initiative for mental health has led to the development of Personal Helpers and Mentors Program to assist individuals with severe MI toward re-connection and recovery, and of the participating sites, include employment support services (Families, Housing, Community Services and Indigenous Affairs, FaHCSIA 2007). Peer and carer support programs within a disability employment program provide an opportunity for people in similar situations to come together to access mutual support, work through issues which may be affecting their work performance, share techniques in overcoming performance pressures, anxieties and other workplace issues.

### **Limitations of the Study**

Limitations relate to the access to the client sample, possible response bias and client sample size. Access to clients was limited in this study as we engaged two participating DEN programmes from a potential of about 69 DEN organisations available in the State in which the study occurred. The potential participants for this study were also limited given that we recruited only those who were English speaking. This limitation relates specifically to funding that would be required for translation of instruments used and other resources (i.e. transcription of qualitative data, use of an interpreter) required for participants from a non-English speaking background. Response bias in the client cohort related to their preferred mode of participation. Client participants indicated a preference for participation in a one-one interview or focus groups in which they said they could explain themselves more comprehensively than through the completion of a survey. The research team considered a number of factors relative to this preference; such as: writing and comprehension skills; educational background; personal preference: concentration level; trust; and/or MI symptomatology. With a client cohort size (N=35), it is likely that 'true' effects in the population will not show up as significant in the results. However the existence of an association was achieved through analyses, therefore producing meaningful results.

### **Future Directions and Recommendations**

This pilot study revealed a largely diverse knowledge base of MI amongst employment counsellors. Employment counsellors' mental health knowledge was highlighted in our study as an important enabler for clients towards being engaged, developing trust and re-connecting with the notion and action of being employed. The results of this research also highlight the fragmentation of services that work towards re-engaging into the workforce those who experience mental illness. Employment support services may well be better placed to enhance client outcomes where more formal communication channels are developed with mental health professions. These formal links to local mental health services can facilitate the opportunity for greater access to secondary consultation as required.

Wider research into the enablers and barriers identified by those who experience MI is important to continue in terms of identifying key concerns that impact on their re-connection with the community by of employment.

Professional development for employment counsellors is also suggested by the results of this pilot study as an area for further development. Education related to such topics as: advanced communication skills, mental state assessment and referral, and managing

challenging behaviours were identified as fundamental knowledge in working with clients experiencing mental illness.

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